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5-1-2013

# Rationing Healthcare: Death Panels & the ACA

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### Recommended Citation

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## Rationing Healthcare: Death Panels & the ACA

Much has been made of the new Patient Protection and Affordable Care Act (ACA) passed in 2010.<sup>1</sup> The name itself has become a point of contention, along with much of what is contained in the law. The term “Obamacare” was coined, it’s arguable by who, to describe the law and was originally used derisively but has since become commonplace.<sup>2</sup> During the presidential debates, President Obama said the name has grown on him to the point where he likes it.<sup>3</sup> This back and forth between those who support and those who oppose the law starts with the title on page one and continues throughout the entire thousand plus pages of the ACA. It is difficult for even an interested observer to parse fact from fiction and reality from exaggeration when it comes to what this law will actually do.<sup>4</sup> Depending on which poll you look at, roughly fifty-five percent of Americans oppose the law, with forty-five percent supporting it.<sup>5</sup> However, individual aspects of the ACA have broad support, such as allowing children to stay on their parents insurance until the age of 26 or insurance companies not being allowed to deny coverage based on a preexisting condition.<sup>6</sup> This signifies a sort of disconnect in the minds of Americans as to what this new law is all about and how it will impact their lives. This article will focus on the now infamous “death panels” claim by Sarah Palin.<sup>7</sup> Looking into the basis of the “death panel” claim and analyzing the relevant portions of the ACA, specifically

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<sup>1</sup> 42 USCA § 18001 (2010).

<sup>2</sup> Elspeth Reeve, *Who Coined ‘Obamacare,’* [www.theatlanticwire.com](http://www.theatlanticwire.com) (Oct. 26, 2011).

<sup>3</sup> Commission on Presidential Debates, [www.2012presidentialelectionnews.com/2012-debate-schedule](http://www.2012presidentialelectionnews.com/2012-debate-schedule) (Oct. 3, 2012).

<sup>4</sup> Gabriel Debenedetti, *Americans Have Mixed Feelings About Healthcare*, [www.reuters.com](http://www.reuters.com) (Oct. 4, 2012).

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> Sarah Palin, *Statement on the Current Health Care Debate*, [www.facebook.com](http://www.facebook.com) (Aug. 7, 2009).

the Independent Payment Advisory Board (IPAB), will provide insight into the issue of rationing healthcare and explain the reality of at least one provision of the ACA.

The rationing of healthcare is a reality. When resources are scarce, as is healthcare, the distribution of the healthcare goods or services must be allocated among its potential users through either explicit or implicit rationing.<sup>8</sup> With explicit rationing, the price of the goods and services rations the scarce resources.<sup>9</sup> With implicit rationing, priorities are decided upon and the allocation of the scarce resources is distributed according to those priorities.<sup>10</sup> Great Britain and many other countries with universal healthcare rely primarily on explicit rationing, while the United States relies more on implicit rationing of healthcare resources.<sup>11</sup> Either way human beings all want access to healthcare resources and clear eyed decisions about how best to accomplish that must be made. Rationing must be understood in order to evaluate the effectiveness, which is determined through the tricky goal of reducing cost while improving results. Fear mongering about rationing may provide may short term benefits but may harm the very serious decisions surrounding the rationing of healthcare. Support for the ACA has stayed roughly the same over the past couple years and thirty-nine percent of Americans believe there is some form of a death panel as part of the ACA.<sup>12</sup> This is not an issue of whether or not healthcare will be rationed in one form or another, because that is the reality. It is important to dispel inaccuracies so the public can have an accurate understanding to make an informed decision about what is the best way to ration healthcare.<sup>13</sup>

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<sup>8</sup> Uwe Reinhardt, *'Rationing' Health Care: What Does It Mean*, [www.nytimes.com](http://www.nytimes.com) (July 3, 2009).

<sup>9</sup> Don Taylor, *Explicit v. Implicit Rationing*, [www.theincidentaleconomist.com](http://www.theincidentaleconomist.com) (Jan. 6, 2012).

<sup>10</sup> *Id.*

<sup>11</sup> Patrick Cox, *United Kingdom, Rationing by Cost*, [www.rationinghealth.org](http://www.rationinghealth.org) (2012).

<sup>12</sup> Robert Field, *Death Panels Live On*, [www.philly.com](http://www.philly.com) (Sep. 28, 2012).

<sup>13</sup> Patrick Cox, *United Kingdom, Rationing by Cost*, [www.rationinghealth.org](http://www.rationinghealth.org) (2012).

The purpose of this article is not to disprove or demonize the death panel claim by Sarah Palin, but to show how sensationalistic claims can have actual harm. By understanding the premise of Governor Palin's argument and dispelling the false or misleading aspects, the public can have a true understanding of the serious decisions we must make regarding healthcare rationing. Heated debate and strong passions have dominated the news regarding the ACA. The nexus of the ACA and the "death panels" claim relating to healthcare rationing is the focus of this article.<sup>14</sup>

In Part I, I will look into the basis of Governor Palin's claim and its relevance to the actual law. I will also look at the legal and political effects of her statements. In Part II, I will analyze the portions of the ACA that relate to her claim. Specifically, I will describe the role of the Independent Payment Advisory Board (IPAB), which is a target of attack for potential healthcare rationing.<sup>15</sup> Also, the goals of specific provisions of the new law will be discussed, as well as, the political realities of passing and implementing the various aspects. Finally, I will analyze case law regarding the constitutionality of the IPAB to provide a legal background. In Part III, I will describe how healthcare is currently rationed by the government and by private insurers in the United States. Also, I will describe the system of rationing healthcare in Great Britain and then compare the two systems. The purpose of Part III is to show how, "the struggle politically, socially, and ethically over the design and impact of our healthcare system depends in large part on wealth as a distributive mechanism."<sup>16</sup> In Part IV, I will provide insight into the fears of rationing healthcare based on the facts and perceptions of the general public. I will then detail the reality of rationing healthcare and what the "death panel" claim really means. In Part V, I

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<sup>14</sup> Sarah Palin, *Statement on the Current Health Care Debate*, [www.facebook.com](http://www.facebook.com) (Aug. 7, 2009).

<sup>15</sup> 42 USCA § 18001 (2010).

<sup>16</sup> Barry R. Furrow, Thomas L. Greaney, *Bioethics: Health Care Law and Ethics* 453 (6<sup>th</sup> ed. 2008).

will apply the realities of allocating healthcare resources to the healthcare debate and discussion going forward.

## I. The Death Panel Claim

On August 7, 2009 Sarah Palin posted a ‘Statement on the Current Healthcare Debate’ on her Facebook page.<sup>17</sup> Governor Palin then spoke publicly about her claim as a contributor for Fox News.<sup>18</sup> In her post she wrote,

“And who will suffer most when they ration care? The sick, the elderly, and the disabled of course. The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama’s ‘death panel’ so his bureaucrats can decide, based on a subjective judgment of their level of productivity in society, whether they are worthy of health care. Such a system is downright evil.”<sup>19</sup>

The basis and relevance of this portion of her statement will first be analyzed.

Governor Palin’s Facebook post was about a proposal in the ACA that would allow Medicare to pay for patients to discuss living wills and other end of life issues with their doctor.<sup>20</sup> Her statements helped create a huge political and public outcry that resulted in the language being removed from the final legislation and proves the impact and relevance of her statement. “In 2011, the Obama administration even deleted all references to end-of-life planning in a new Medicare regulation when opponents interpreted the move as a back-door

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<sup>17</sup> Sarah Palin, *Statement on the Current Health Care Debate*, [www.facebook.com](http://www.facebook.com) (Aug. 7, 2009).

<sup>18</sup> SarahPAC, *Sarah’s Story*, [www.sarahpac.com](http://www.sarahpac.com) (2012). (Palin offers political commentary and analysis across all FOX news platforms. Palin gained national recognition in August 2008 when Senator John McCain chose Palin to serve as his vice-presidential running mate in his presidential campaign, making her the first woman to run on the Republican Party’s presidential ticket. Prior to that she served as governor of Alaska until July 2009 when she resigned with 18 months left in her term to focus on her other interests.)

<sup>19</sup> Sarah Palin, *Statement on the Current Health Care Debate*, [www.facebook.com](http://www.facebook.com) (Aug. 7, 2009).

<sup>20</sup> Glenn Kessler, *Sarah Palin, Death Panels and Obamacare*, [www.washingtonpost.com](http://www.washingtonpost.com) (June 27, 2012).

effort to allow such planning.”<sup>21</sup> It is important to note the amount and passion of reaction to Governor Palin’s claim. Democrats led by the President and leaders from both the House (Nancy Pelosi) and Senate (Harry Reid) called her claims a distraction and fear mongering intended to scare people from supporting the ACA.<sup>22</sup> Even people in the Republican establishment like conservative columnist David Brooks slammed her claim as ‘crazy’ and Rep. Jack Kingston labeled it a ‘scare tactic.’<sup>23</sup> In response, Governor Palin’s next post called for some civility,

“There are many disturbing details in the current bill that Washington is trying to rush through Congress, but we must stick to a discussion of the issues and not get sidetracked by tactics that can be accused of leading to intimidation or harassment. Such tactics diminish our nation’s civil discourse which we need now more than ever because the fine print in this outrageous healthcare proposal must be understood clearly and not get lost in conscientious voters’ passion to want to make elected officials hear what we are saying. Let’s not give the proponents of nationalized healthcare any reason to criticize us.”<sup>24</sup>

This debate continued as efforts to repeal the ACA were mounted. The conversation changed course on June 28, 2012, when the Supreme Court upheld the Patient Protection and Affordable Care Act in a landmark 5-4 ruling.<sup>25</sup> At that same time Governor Palin decided to provide more information about her original Facebook post from three years earlier. She made the following clarification of specifically what portion of the ACA she was targeting. Governor Palin was referencing the IPAB, created in the law, saying “its purpose all along has been to ‘keep costs down’ by actually denying care via price controls and typically inefficient

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<sup>21</sup> *Id.*

<sup>22</sup> Steve Benen, *Conservatives Slam Palin Attack*, [www.washingtonmonthly.com](http://www.washingtonmonthly.com) (Aug. 9, 2009).

<sup>23</sup> *Id.*

<sup>24</sup> Rachel Weiner, *After “Death Panel” Claim, Palin Now Calls for Civility*, [www.huffingtonpost.com](http://www.huffingtonpost.com) (Sep. 10, 2009).

<sup>25</sup> *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. (2012). (The Supreme Court upheld President Obama’s health care overhaul law, saying its requirement that most Americans obtain insurance or pay a penalty was authorized by Congress’s power to levy taxes. The vote was 5 to 4, with Chief Justice John G. Roberts Jr. joining the court’s four more liberal members.)

bureaucracy.”<sup>26</sup> She added that “this subjective rationing of care is what I was writing about in that first post.”<sup>27</sup>

## II. IPAB

### A. Structure and Goals

The IPAB is created under Section 3403 of the ACA as an independent board comprised of fifteen members appointed by the President with the advice and consent of the Senate.<sup>28</sup> “The fifteen members of IPAB will be nationally recognized experts in the fields of health facility and health plan management, actuarial science, and health finance and payment.”<sup>29</sup> “Three of the members will be officials of the Department of Health and Human Services.”<sup>30</sup> Target Medicare growth rates are set and the goal of the IPAB is to keep the growth rates in line with targets.<sup>31</sup> The planned process will entail the IPAB proposing cuts to Congress and the President in January of each year.<sup>32</sup> Congress may then debate the proposals for no more than thirty hours.<sup>33</sup> Congress must then pass legislation achieving the required reductions in Medicare spending by August.<sup>34</sup> If they fail to act, the proposed recommendations automatically go into effect and there are no administrative or judicial reviews permitted.<sup>35</sup> “In addition to submitting proposals to curb Medicare spending, the IPAB is also tasked with submitting annual reports to Congress regarding issues of cost, access, quality and utilization of healthcare services for private payers

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<sup>26</sup> Glenn Kessler, *Sarah Palin, Death Panels and Obamacare*, [www.washingtonpost.com](http://www.washingtonpost.com) (June 27, 2012).

<sup>27</sup> *Id.*

<sup>28</sup> Ann Marie Marciarille, J. Bradford DeLong, Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board, 22 *Health Matrix* 75, 118 (2012).

<sup>29</sup> Laura B. Morgan, The Independent Payment Advisory Board: Will It Effectively Curb the Medicare Growth Rate?, 20 *Annals Health L. Advance Directive* 124, 128 (2011).

<sup>30</sup> *Id.*

<sup>31</sup> Ann Marie Marciarille, J. Bradford DeLong, Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board, 22 *Health Matrix* 75, 118 (2012).

<sup>32</sup> Sara Margolis, Independent Payment Advisory Board Review Put On Hold, CBLR Online (2012).

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

and Medicare, as well as, to submitting non-binding recommendations to curb the growth of private national healthcare spending.”<sup>36</sup> Congress may attempt to repeal the IPAB by “introducing a Joint resolution to dissolve the IPAB by February 2017.”<sup>37</sup> If the resolution passes the House and Senate by August of that year, the IPAB would be abolished by 2020.<sup>38</sup> The fifteen member IPAB board has yet to be established but when it begins its work, the first major task will be to alter the process by which Medicare sets reimbursement rates.

“Through the IPAB, the ACA is an experiment in binding citizens to socially optimal Medicare payment decisions by removing much of Congress’s discretion on these matters. The IPAB represents the latest, and strongest, independent expert panel dedicated to reducing the *per capita* rate of growth in Medicare spending. Based on the assumption that Congress and the federal administrative agencies have proven themselves too accommodating to the provider, payor and consumer forces that propel an ever increasing Medicare spending growth rate, the IPAB is designed to limit the growth of Medicare spending and improve the governance structure for Medicare.”<sup>39</sup>

The power of the board lies in the fact that the IPAB recommendations will become law by default if Congress fails to act. This frees them up to make objective decisions on how to reduce Medicare spending growth while enhancing Medicare beneficiary access to quality care.<sup>40</sup> The goal is not to cap Medicare’s spending growth so as to align it with general inflation rates but to grow it a “rate necessary to provide quality care as effectively as possible.”<sup>41</sup>

The ACA also places limits on the authority of the IPAB. The ACA states, “[t]he IPAB may not recommend rationing of healthcare, raising Medicare beneficiary premiums, cost

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<sup>36</sup> Laura B. Morgan, The Independent Payment Advisory Board: Will It Effectively Curb the Medicare Growth Rate?, 20 Annals Health L. Advance Directive 124, 128 (2011).

<sup>37</sup> Sara Margolis, Independent Payment Advisory Board Review Put On Hold, CBLR Online (2012).

<sup>38</sup> *Id.*

<sup>39</sup> Ann Marie Marciarille, J. Bradford DeLong, Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board, 22 Health Matrix 75, 118 (2012).

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*



sharing, or modifying eligibility criteria.”<sup>42</sup> This is totally contrary to the “death panels” claim made by Governor Palin and illustrates the concern and confusion over the IPAB’s statutory and regulatory role. Also, Medicare specifically “withholds the power to regulate the practice of medicine from the federal government.”<sup>43</sup> The IPAB has significant limitations on the scope of its proposals. So, as per ACA law, the IPAB cannot submit any proposals that would “ration care, modify Medicare eligibility criteria, raise costs to beneficiaries, change cost sharing for covered services, or restrict benefits in any way.”<sup>44</sup> Hospitals and hospices are already receiving a reduction in their payments under the ACA, so the IPAB may not recommend any further cuts to them until 2020.<sup>45</sup> What will happen after 2020 remains unclear as the ACA is likely to undergo additional changes between now and then.

#### B. Constitutionality and Implementation

There were many cases filed challenging the constitutionality of the ACA. The most famous being the *National Federation of Independent Business v. Sebelius* case which reached the Supreme Court.<sup>46</sup> One of the many cases that did not, *Coons v. Geithner*, was brought by several members of the Arizona Congressional delegation challenging the constitutionality of the IPAB provision of the ACA on several grounds.<sup>47</sup> The primary argument being the IPAB circumvents Congress’ “power and right to consider, review, debate and vote on the legislative

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<sup>42</sup> 42 USCA § 18001 (2010).

<sup>43</sup> Ann Marie Marciarille, J. Bradford DeLong, Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board, 22 Health Matrix 75, 118 (2012).

<sup>44</sup> Laura B. Morgan, The Independent Payment Advisory Board: Will It Effectively Curb the Medicare Growth Rate?, 20 Annals Health L. Advance Directive 124, 128 (2011).

<sup>45</sup> *Id.*

<sup>46</sup> Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. (2012).

<sup>47</sup> Coons v. Geithner, CV-10-1714-PHX-GMS, 2012 WL 3778219 (D. Ariz. Aug. 31, 2012).

proposals of IPAB like any other legislative proposal.”<sup>48</sup> The ACA limits debate on IPAB proposals to thirty hours and the plaintiffs argue that their ability to perform their duty and debate legislation is compromised.<sup>49</sup> The plaintiffs also argue the IPAB exceeds Congressional power by binding future Congresses to accept the current Congress’ legislation.<sup>50</sup> Citing Article I § 5 of the Constitution, the complaint alleges, “the parliamentary rulemaking power of each House does not include the power to entrench, by statute, parliamentary rules from alteration by the Houses of future Congresses.”<sup>51</sup> The plaintiffs also argue against the lack of judicial or administrative review by alleging in the complaint that, “even where the legislative power of Congress is delegated to an executive agency with an intelligible principle to guide its exercise, judicial review must be preserved to ensure the agency stays within the bounds set by Congress.”<sup>52</sup> The fundamental issue is allowing an unelected federal board the potential to have more power than the Constitution intended. That power could affect the healthcare of the American people. Since the Supreme Court ruling upheld the ACA this case has been dismissed and the issue is currently on hold. The attorney for the plaintiff summarizes his argument by saying, “No possible reading of the Constitution supports the idea of an unelected, stand-alone federal board that’s untouchable by both Congress and the courts.”<sup>53</sup>

Similar structures to the one created by the ACA for the IPAB have been held constitutional by the Supreme Court. “In 1990, Congress created the Defense Base Realignment and Closure Committee (BRAC) to make difficult recommendations about military base

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<sup>48</sup> Ann Marie Marciarille, J. Bradford DeLong, Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board, 22 Health Matrix 75, 118 (2012).

<sup>49</sup> *Id.*

<sup>50</sup> Coons v. Geithner, CV-10-1714-PHX-GMS, 2012 WL 3778219 (D. Ariz. Aug. 31, 2012).

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> Sara Margolis, Independent Payment Advisory Board Review Put On Hold, CBLR Online (2012).

closures.”<sup>54</sup> “Multiple states sued, and the Court held that BRAC recommendations were not final agency action, and therefore, not reviewable under the Administrative Procedure Act.”<sup>55</sup> “Those who argue in favor of the IPAB point to its parallels with the BRAC when defending the constitutionality of the IPAB concept.”<sup>56</sup>

Even though Governor Palin may fear that the IPAB will lead to the rationing of healthcare, the legislation specifically prohibits rationing.

“Although many of these concerns are legitimate, there are also many reasons to be optimistic about the IPAB's potential. Also, the fear of a “government takeover” through the IPAB is not substantiated because Medicare itself is a federal government program, and the IPAB's recommendations are only binding on issues related to Medicare spending. While it is true that the IPAB shifts the balance of power from the legislative branch to the executive branch, this is a necessary component of the IPAB. Congress has been unable to make major Medicare cost reform in the past due to special interests and the political unpopularity of making cuts to the Medicare program. Moreover, there are numerous safeguards in place to keep the IPAB accountable to voters.”<sup>57</sup>

As for the constitutionality of the IPAB, the Supreme Court has approved broad delegations of authority as long as Congress imposes an “intelligible principle” to guide the exercise of discretion.<sup>58</sup> However, Congress cannot delegate its responsibility and authority to adopt legislation to the executive branch even though they must often grant executive agencies considerable discretion to implement complex bodies of regulatory law.<sup>59</sup> The framers of the ACA were very careful to provide detailed limitations on the IPAB and the Supreme Court has

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<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> Timothy Stoltzfus Jost, The Real Constitutional Problem with the Affordable Care Act, 36 J. Health Pol. Pol'y & L. 501, 503 (2011).

<sup>59</sup> *Id.*

shown deference to congressional delegation of authority. A concern for the Supreme Court may be delegations of authority that lack the ACA's substantial limitations on IPAB authority.<sup>60</sup> In addition, no law has been struck down under a delegation challenge since the 1930s and IPAB's framers were careful to limit its authority over matters beyond Medicare payment reform.<sup>61</sup> These details are difficult to explain in a few short sound bites or even in a debate, which heighten the importance of open and honest dialogue.

### III. Rationing Healthcare

Healthcare is a scarce resource and how a society decides to allocate that resource defines how they ration. The healthcare systems in the United States and Great Britain vary greatly, and the ethical issues around rationing differ substantially. In the United States they largely revolve around rationing care by ability to pay and eligibility for insurance coverage. In Great Britain they have a universal system that is more concerned with providing health services to everyone. The challenge for both the United States and for Great Britain is to simultaneously increase access, decrease costs, and improve the quality of their respective healthcare systems. Implicit rationing occurs in the American healthcare system by both the government and by private insurers. Implicit rationing refers “to discretionary decisions made by managers, professionals, and other health personnel functioning within a fixed budgetary allowance.”<sup>62</sup> In Great Britain, the government has a clear policy of explicitly rationing healthcare to control cost. Rationing is widely accepted and generally not viewed negatively by British citizens. Explicit rationing refers to, “decisions made by an administrative authority as to the amounts and types of resources to be made available, eligible populations, and specific rules for allocation, along with,

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<sup>60</sup> Ann Marie Marciarille, J. Bradford DeLong, Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board, 22 Health Matrix 75, 118 (2012).

<sup>61</sup> *Id.*

<sup>62</sup> Don Taylor, *Explicit v. Implicit Rationing*, [www.theincidentaleconomist.com](http://www.theincidentaleconomist.com) (Jan. 6, 2012).

explicit rationing in public and private plans regarding levels of available technology, locations of facilities and expenditure levels.”<sup>63</sup> I will compare and contrast the systems of allocating healthcare by the United States and Great Britain.

The history and experiences with rationing of both Nations helps to inform and define how they each ration healthcare today. When World War II began the United States government realized that many resources were needed for the war effort and began to ration food, gas, clothing and other goods.<sup>64</sup> The government controlled the supply and demand to ensure that everyone got at least some of the necessary resources they needed.<sup>65</sup> The government made efforts to persuade Americans to conserve and to choose goods that were less scarce.<sup>66</sup> The concept of this form of rationing was that goods are denied to those who can afford to buy them if they want more than their equitable share.<sup>67</sup> However, not long after the war ended, so did the rationing program and the concepts did not engrain themselves into American culture. The United States is a large diverse country with a strong tradition of valuing individual liberty. Great Britain also had a rationing program during and after World War II. Their rationing program was larger, stronger and longer lasting than the American rationing system. During World War II and for a number of years after, the British government rationed most food items and strictly controlled the supply of items such as gasoline.<sup>68</sup> This was viewed and understood as being in the best interest of the nation. Although there was wartime rationing elsewhere, including in the United States, it generally applied to fewer items over fewer years and was

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<sup>63</sup> *Id.*

<sup>64</sup> <http://www.u-s-history.com/pages/h1674.html>.

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> Kelli Back, Rationing Health Care: Naturally Unjust?, 12 Hamline J. Pub. L. & Pol'y 245 (1991).

<sup>68</sup> Patrick Cox, *United Kingdom, Rationing by cost*, [www.rationinghealth.org](http://www.rationinghealth.org) (2012).

quickly forgotten when it was longer needed.<sup>69</sup> In Great Britain, however, rationing became a part of the national identity and helped to influence the creation of their current healthcare rationing framework.

The United States relies on a mix of public and private financing with multiple payers and spends more on healthcare than any other nation. About sixty-four percent of the United States population has private health insurance and the rest either have government insurance or no insurance at all.<sup>70</sup> The United States spends eighteen percent of GDP on healthcare, which is fifty percent more *per capita* than any other country.<sup>71</sup> There are about forty-five million Americans receiving Medicare coverage and about forty-nine million Americans covered by Medicaid.<sup>72</sup> In addition, the ACA will greatly expand the number of families on Medicaid and provide significant subsidies to many purchasing insurance through the state-based exchanges.<sup>73</sup> With more voters than ever dependent on public funding for their health care, politicians in both parties may be very reluctant to embrace rationing schemes in government programs. Explicit rationing processes exposed in public forums are the most vulnerable to politically motivated attacks. Governor Palin has proven that by simply utilizing Facebook and FOX News to gain notoriety of her claims. The ongoing debate about the possible role of comparative effectiveness research in healthcare reform illustrates the political difficulty of rationing health care.<sup>74</sup> The CBO issued a report indicating that increased federal funding for comparative effectiveness

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<sup>69</sup> *Id.*

<sup>70</sup> Emily Smith, *By The Numbers: Health Insurance*, [www.cnn.com](http://www.cnn.com) (June 28, 2012).

<sup>71</sup> Steven Teutsch, Ethics of Resource Allocation- US and Europe, *Public Health Reviews*, Vol. 34, No 1 (2012).

<sup>72</sup> Emily Smith, *By The Numbers: Health Insurance*, [www.cnn.com](http://www.cnn.com) (June 28, 2012).

<sup>73</sup> Leonard J. Nelson, III, Rationing Health Care in Britain and the United States, 7 *J. Health & Biomedical L.* 175 (2011).

<sup>74</sup> *Id.*

research could result in reduced health care expenditures in federal programs without adverse effects on the aggregate quality of health care.<sup>75</sup>

In the United States there is an implicit rationing system by both the government (Medicare and Medicaid) and by private insurers. Through private insurers healthcare is rationed based on the ability to pay and/or get coverage. Private insurers ration by not covering certain procedures, medicine, or by denying care based on pre-existing conditions.<sup>76</sup> The decision is made by insurance company underwriters with a profit motive as the bottom line. As President Obama put it,

“Right now, insurance companies are rationing care. They are basically telling you what’s covered and what’s not. They’re telling you, “We’ll cover this drug but we won’t cover that drug. You can have this procedure or you can’t have that procedure.” Why is it that people would prefer having insurance companies make those decisions rather than medical experts and doctors figuring out what are good deals for care and providing that information to you as a consumer and your doctor so that you could make the decision?”<sup>77</sup>

Governor Palin would argue that under the ACA government bureaucrats would ration care instead of the decisions being made by doctors and medical experts. Either way you look at it, healthcare is a scarce resource that must be either implicitly or explicitly rationed. The idea of pure competition and free markets systems is not truly the type of private insurance that Americans actually have because the ability to pay is usually based on insurance coverage provided by their employer.<sup>78</sup> To have a real free market system, consumers would have to make all the decisions, which is not the case with private insurers who either make the decision

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<sup>75</sup> *Id.*

<sup>76</sup> Michael Gusmano & Sara Allin, Health Care for Older Persons in England and the United States: A Contrast of Systems and Values, 36 J. Health Pol. Pol’y & L. 89, 91 (2011).

<sup>77</sup> Laura Conway, *Obama Says His Health Plan Won’t Pull the Plug on Grandma*, Post on Planet Money Blog, NPR (Aug. 11, 2009).

<sup>78</sup> Amanda Swanson, Rationing As a Necessity, 19 Annals Health L. Directive 1 (2009).

themselves or rely on the doctor to tell the consumer what they may have.<sup>79</sup> Also, the consumer must know and pay the actual value of the goods or service, which is also not the case with private insurers because typically the consumer is only responsible for co-pays and premiums without ever really knowing the full actual cost.<sup>80</sup> There is also Roemer's law which helps explain how supply affects demand in healthcare.<sup>81</sup> "Many studies that have been conducted to understand this occurrence reveal that, when the resources are available, doctors will increase the number of treatments or procedures performed without necessarily targeting those patients who need them most."<sup>82</sup> So when doctors have more healthcare resources they perform more procedures, but the market does not allocate the resources efficiently in this context. The current private healthcare system in the United States uses implicit rationing, which will likely continue under the ACA, and implicit rationing techniques are also used by the large government programs, Medicare and Medicaid.

Medicare and Medicaid ration "by eligibility requirements, the number of services for which the programs will pay, and through the protocol that must be followed to get a service reimbursed."<sup>83</sup> These decisions are made by government underwriters. However, Medicare does not ration based on preexisting conditions and cannot turn down applicants based on health history.<sup>84</sup> One example of this is the End Stage Renal Disease dialysis program under Medicare, in which, high demand for kidney dialysis drove up the price and caused rationing.<sup>85</sup> The government ended the rationing by expanding Medicare coverage to make sure everyone could

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<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> Kelli Back, Rationing Health Care: Naturally Unjust?, 12 Hamline J. Pub. L. & Pol'y 245 (1991).

<sup>84</sup> Michael Gusmano & Sara Allin, Health Care for Older Persons in England and the United States: A Contrast of Systems and Values, 36 J. Health Pol. Pol'y & L. 89, 91 (2011).

<sup>85</sup> Kelli Back, Rationing Health Care: Naturally Unjust?, 12 Hamline J. Pub. L. & Pol'y 245 (1991).



get the procedure.<sup>86</sup> The rationing in the United States is done implicitly because the public and therefore the government will not accept explicit rationing.

In contrast, the healthcare system in Great Britain does explicitly ration healthcare. After World War II, the British government created the National Health Service (NHS) to provide universal healthcare to its citizens.<sup>87</sup> Over ninety-five percent of British citizens get their health care through the government run program.<sup>88</sup> Rationing has become part of the national identity and in order to provide care to everyone the government places limits on the care it provides by rationing.<sup>89</sup> Great Britain spends about nine percent of GDP on healthcare.<sup>90</sup> There are numerous elements that embody the NHS and its guiding principles. The seven essential characteristics are:

“(1) government ownership of most hospitals; (2) consultants (specialists) attached to the hospitals; (3) government contracts with general practitioner to provide primary care services; (4) universal coverage financed by taxes; (5) care free at the point of delivery (with charges added later for prescription drugs and dentistry); (6) private practice permitted for NHS doctors, including private pay beds in NHS hospitals; and (7) clinical freedom for general practitioners who control access to hospitals and consultants.”<sup>91</sup>

These characteristics make up the universal healthcare system for Great Britain. By explicitly rationing healthcare the NHS is able to keep costs to about \$3,800 per person.<sup>92</sup> A different government agency was created to actually make the decisions on how to ration.

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<sup>86</sup> *Id.*

<sup>87</sup> Patrick Cox, *United Kingdom, Rationing by cost*, [www.rationinghealth.org](http://www.rationinghealth.org) (2012).

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> Amanda Swanson, *Rationing As a Necessity*, 19 *Annals Health L. Directive* 1 (2009).

<sup>91</sup> Leonard J. Nelson, III, *Rationing Health Care in Britain and the United States*, 7 *J. Health & Biomedical L.* 175 (2011).

<sup>92</sup> Joanne Silberner, *Britain Weighs Social Cost of ‘Wonder’ Drugs*, [www.npr.org](http://www.npr.org) (2008).

The governmental agency tasked with deciding which drugs and other treatments can be prescribed by NHS doctors is the National Institute of Health and Clinical Excellence (NICE).<sup>93</sup> “NICE was created to clarify the reasons why certain drugs are approved and others are rejected, instead of those decisions being made behind closed doors.”<sup>94</sup> One example of a drug that is available in the United States but not covered by NICE, is the very expensive cancer medication Tarceva.<sup>95</sup> NICE weighed the drug effectiveness, its cost, and its ability to extend life and determined it was not worth the price.<sup>96</sup> Another example was NICE refusing to approve certain drugs for kidney cancer because even though the drug was effective, the extremely high cost was the deciding factor.<sup>97</sup> In that situation political pressure resulted in the drug subsequently being approved, through increased funding from both public and private sources.<sup>98</sup> This may signal a slight change for the future but explicit rationing is commonplace and generally accepted by British citizens. “The rationing decisions start with the basic premise that the government should spend its limited resources on treatments that do the most good for the money.”<sup>99</sup> “NICE calculates cost-effectiveness with a widely used measure called a quality-adjusted life year (QALY).”<sup>100</sup> “NICE tends to assume that the most common treatments are cost effective and sets a maximum that it will spend on a treatment, about \$47,000 per QALY.”<sup>101</sup> Over the years, various governments from differing political parties have all been supportive of the NHS and have also placed budget limitations on them to contain costs. The rationing decisions are generally made with the overall good in mind and not focused on the individual. “Various

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<sup>93</sup> Patrick Cox, *United Kingdom, Rationing by cost*, [www.rationinghealth.org](http://www.rationinghealth.org) (2012).

<sup>94</sup> *Id.*

<sup>95</sup> Joanne Silberner, *Britain Weighs Social Cost of ‘Wonder’ Drugs*, [www.npr.org](http://www.npr.org) (2008).

<sup>96</sup> *Id.*

<sup>97</sup> Leonard J. Nelson, III, Rationing Health Care in Britain and the United States, 7 J. Health & Biomedical L. 175 (2011).

<sup>98</sup> *Id.*

<sup>99</sup> Patrick Cox, *United Kingdom, Rationing by cost*, [www.rationinghealth.org](http://www.rationinghealth.org) (2012).

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

approaches to rationing have been used throughout the history of the NHS, such as waiting lists, limited deployment of new technologies, strict budget limitations that have required physicians to engage in bedside rationing, and explicit rationing through the use of cost-effectiveness analysis.”<sup>102</sup> There is also a market for private insurance in Great Britain but it only covers elective procedures and has not been an effective substitute for the essential care provided by the NHS.<sup>103</sup>

Some American healthcare experts wanted to establish an agency like NICE but the idea was scrapped after Sarah Palin made her death panel claims and she has even compared the IPAB to NICE.<sup>104</sup> Great Britain and the United States both must contain the ever rising cost of healthcare by whatever form rationing they choose. Whether it is implicit or explicit, it is still rationing. Rationing is usually described as “the administrative distribution of goods in the market that are physically scarce or in the case of products deemed essential for ordinary living, scarce at a socially acceptable price.”<sup>105</sup> Regardless of how much is spent on healthcare by a nation, increasing performance in one area of the healthcare system can compromise performance in another. It is very difficult to simultaneously increase access, decrease costs, and improve the quality of a healthcare system.<sup>106</sup> The United States and Great Britain both rely on a mix of public and private systems of financing with the United States having a more hybrid system while Great Britain has a vastly public system.

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<sup>102</sup> Leonard J. Nelson, III, Rationing Health Care in Britain and the United States, 7 J. Health & Biomedical L. 175 (2011).

<sup>103</sup> *Id.*

<sup>104</sup> Ann Marie Marciarille, J. Bradford DeLong, Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board, 22 Health Matrix 75, 118 (2012).

<sup>105</sup> Kelli Back, Rationing Health Care: Naturally Unjust?, 12 Hamline J. Pub. L. & Pol'y 245 (1991).

<sup>106</sup> Michael Gusmano & Sara Allin, Health Care for Older Persons in England and the United States: A Contrast of Systems and Values, 36 J. Health Pol. Pol'y & L. 89, 91 (2011).

Either system of rationing can affect the breadth of coverage, the scope of coverage, and the depth of coverage.<sup>107</sup> “Rationing the breadth of coverage reduces the proportion of the population eligible for coverage, by means testing, excluding the self employed, pricing people out, excluding eligibility, or allowing people to opt out.”<sup>108</sup> “Rationing the scope of care by excluding services from the benefits package reduces the quantity or quality of clinical care, through the application of measures like comparative effectiveness or through the use of waiting lists.”<sup>109</sup> “Rationing the depth of coverage involves user charges based on the value of healthcare services and applies selective charges (co-payments) for inefficient services.” However the implicit or explicit rationing is carried out, the first task is making an ethical decision based on “balancing fiscal constraints with healthcare system goals such as equity, efficiency and improving population health, as well as broader societal values.”<sup>110</sup> Everyone needs healthcare at some point, so everyone is involved and has a stake in this discussion and the decisions that are made.

#### IV. Fear vs. Reality

Governor Palin’s claim that the ACA created “death panels” that would ration healthcare was supported by some and was also found to be false by numerous fact checkers.<sup>111</sup> In an op-ed article for *The Wall Street Journal*, Governor Palin provides some insight into her views on rationing by saying, “the President’s proposals would give unelected officials life-and-death rationing powers” but later echoes Ronald Reagan in saying, “no one in this country should be

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<sup>107</sup> Steven Teutsch, Ethics of Resource Allocation- US and Europe, Public Health Reviews, Vol. 34, No 1 (2012).

<sup>108</sup> *Id.*

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

<sup>111</sup> Leonard J. Nelson, III, Rationing Health Care in Britain and the United States, 7 J. Health & Biomedical L. 175 (2011).

denied medical care because of a lack of funds.”<sup>112</sup> She does not discount the fact that insurance companies can be unaccountable and unresponsive, but she fundamentally believes that government trying to solve problems is only likely on to cause more.<sup>113</sup> However, when digging into her “death panels” claim that the IPAB will ration healthcare, it appears to be an attempt to mislead the public. Healthcare is a limited resource and in order for no one in the country to be denied medical care it must be rationed in some form. The claim is also misleading because the IPAB has limited authority to make recommendations within Medicare, which is a government program. A simple reality is to look at the actual text of the law. Under the ACA, the proposal “shall not include any recommendation to ration healthcare, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria, among other requirements, “[t]he proposal shall only include recommendations related to the Medicare program.”<sup>114</sup>

Any dismissive assumptions about Governor Palins claim is shortsighted, since her statements do actually have an impact they need to be looked at fully. Her claim does draw attention to a central truth, “under highly centralized national healthcare, the government inevitably makes cost-minded judgments about what types of care are ‘best’ for society at large, and the standardized treatments it prescribes inevitably impact life-saving options for individual patients.”<sup>115</sup> Similarly, during the debate over health care reform, President Obama said, “I think there is going to have to be a conversation that is guided by doctors, scientists, ethicists and that

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<sup>112</sup> Sarah Palin, *Obama and the Bureaucratization of Health Care*, [www.wsj.com](http://www.wsj.com) (Sep. 8, 2009).

<sup>113</sup> *Id.*

<sup>114</sup> 42 USCA § 18001 (2010).

<sup>115</sup> Leonard J. Nelson, III, Rationing Health Care in Britain and the United States, 7 J. Health & Biomedical L. 175 (2011).

there's going to have to be a very difficult democratic conversation that takes place (and) it is very difficult to imagine the country making those decisions just through the normal political channels.”<sup>116</sup> There seems to be at least an attenuated connection between the statements by the President and the “death panels” claim by Governor Palin. All resources are scarce, including healthcare, and those resources will be either implicitly or explicitly rationed which will, in turn, limit access to healthcare services in some way.<sup>117</sup> The primary question is not whether healthcare is rationed, but who does the rationing, how do they ration, and to what degree.

The ethical dilemma is how to balance autonomy, beneficence, and distributive justice, within the context of a healthcare system.<sup>118</sup> Autonomy would seem to favor allowing private markets to accomplish the needed rationing by allowing consumer to make their own decisions about how much and what kind of healthcare they want or need.<sup>119</sup>

“Autonomy would suggest that individuals have a right to determine what is in their own best interest, though that interest may be limited if exercising that right limits the rights of others. Beneficence means that clinicians should act completely in the interest of their patients, and distributive justice or equity implies fairness and that all groups have an equal right to clinical services regardless of race, gender, age, income, or any other characteristic. The utilitarian perspective would suggest that resources for medical care should be used to provide the greatest good for the greatest number.”<sup>120</sup>

Beneficence can be applied and even enforced in any healthcare system through strong medical ethics requirements. Distributive justice and the utilitarian perspective apply an approach that is more similar to a universal healthcare approach by a country like Great Britain. Different countries prioritize, “the rights of individuals and the fairness on society as a whole in very

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<sup>116</sup> David Leonhardt, *After the Great Recession*, NY Times (April 28, 2009).

<sup>117</sup> Steven Teutsch, *Ethics of Resource Allocation- US and Europe*, Public Health Reviews, Vol. 34, No 1 (2012).

<sup>118</sup> *Id.*

<sup>119</sup> Elizabeth Weeks Leonard, *Death Panels and The Rhetoric of Rationing*, (Sep. 10,2012).

<sup>120</sup> Steven Teutsch, *Ethics of Resource Allocation- US and Europe*, Public Health Reviews, Vol. 34, No 1 (2012).

different ways and use very different processes for addressing the legitimacy, transparency, and accountability of those explicit or implicit decisions.”<sup>121</sup>

## V. Allocating Healthcare Resources

The now infamous “death panels” claim by Sarah Palin created a great deal of controversy. It is one of the most famous and well known Facebook posts ever made, however, I believe her later Facebook post about civility was much more instructive. She spoke of the harm in diminishing our nation's civil discourse and about how the healthcare proposal must be understood clearly in order for American citizens to make an informed decision about how to best allocate the limited healthcare resources.<sup>122</sup>

Initially, Governor Palin said her Facebook post was about a proposal in the ACA that would force everyone to, “stand in front of Obama’s ‘death panel’ so his bureaucrats can decide, based on a subjective judgment of their level of productivity in society, whether they are worthy of healthcare.”<sup>123</sup> This was a reference to a proposal allowing appointments to discuss living wills and other end of life issues in an attempt to more efficiently allocate healthcare resources to better accord with what patients wanted. An average U.S. citizen spends about one-third of their overall healthcare resources in the last year of their life.<sup>124</sup> By discussing end of life issues, patients are more likely to choose less expensive options, like hospice care, at the end of their lives.<sup>125</sup> This is an important ethical issue worthy of serious debate and conversation. However, Governor Palin’s statement became a rallying cry and focal point of outrage against the entire ACA law and that specific proposal was removed for the final legislation because it became

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<sup>121</sup> *Id.*

<sup>122</sup> Rachel Weiner, *After “Death Panel” Claim, Palin Now Calls for Civility*, [www.huffingtonpost.com](http://www.huffingtonpost.com) (Sep. 10, 2009).

<sup>123</sup> Sarah Palin, *Statement on the Current Health Care Debate*, [www.facebook.com](http://www.facebook.com) (Aug. 7, 2009).

<sup>124</sup> Ann Harding, *End of Life Care Cost Continue to Climb Upward*, [www.reuters.com](http://www.reuters.com) (Oct. 14, 2010).

<sup>125</sup> *Id.*

politically unfeasible to leave it in, as well as, removal of any and all references to end of life planning.

Governor Palin's claim resurfaced again in 2012 and is again impacting the debate on how to allocate healthcare resources. Governor Palin made a clarification by saying that her original post was referencing the IPAB and that its "purpose all along has been to keep costs down by actually denying care via price controls and typically inefficient bureaucracy."<sup>126</sup> The attack was on IPAB and its potential use of rationing and it was also an attack on the concept of rationing itself.

The IPAB is explicitly prohibited from rationing under the ACA.<sup>127</sup> They have limited authority and are tasked with improving efficiency in Medicare, which is a government program. The whole idea of having this independent board is based on the assumption that Congress will not be able to improve efficiency within Medicare for political reasons. The only realistic way the IPAB will improve efficiency are through making decisions on allocating limiting healthcare resources that can only be described as implicit rationing. As for the constitutionality of this process and the IPAB itself, it should be clear now that both are within the law. A board similar to the IPAB, with appropriate limitations, has been held constitutional before and the IPAB is not substantially different. President Obama recently won reelection and the IPAB was even discussed during the presidential debates in small amounts which were likely confusing and

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<sup>126</sup> Sarah Palin, *Statement on the Current Health Care Debate*, [www.facebook.com](http://www.facebook.com) (Aug. 7, 2009).

<sup>127</sup> 42 USCA § 18001 (2010).



unclear to most watching.<sup>128</sup> The ACA has been upheld, for the most part, by the Supreme Court so the IPAB is here to stay, even though it is has not yet been created.<sup>129</sup>

Rationing itself has occurred in the United States throughout our history in both hidden and sometimes more visible ways. Most notably rationing occurred during World War II and again recently in a smaller way with gas rationing after Superstorm Sandy. A hidden way of rationing is the implicit rationing of healthcare in both the private insurance market, as well as, in the Medicare and Medicaid government programs. In the private insurance market, the more money or access to insurance you have, the more healthcare you can get. As for the government programs, we will see how the implicit rationing within IPAB affects Medicare, even though the ACA explicitly states that rationing is prohibited.<sup>130</sup> Any explicit rationing, or implicit rationing labeled as such, will be open to political attack. Especially since the ACA expands the number of people on Medicaid any form of rationing schemes that seem to reduce care will become even more politically unfeasible.<sup>131</sup>

The only path to explicit rationing is public acceptance as is the case in Great Britain and many other industrialized countries. They have a history of explicit rationing which is part of their national identity.<sup>132</sup> The decisions are not made behind closed doors but are clearly stated by the NICE.<sup>133</sup> The rationing starts with the basic premise that the government should spend its limited resources on treatments that do the most good.<sup>134</sup> However, the reality of limited resources occasionally leads to unpopular decisions to deny coverage or that create waiting lists.

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<sup>128</sup> Commission on Presidential Debates, [www.2012presidentialelectionnews.com/2012-debate-schedule](http://www.2012presidentialelectionnews.com/2012-debate-schedule) (Oct. 3, 2012).

<sup>129</sup> *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. (2012).

<sup>130</sup> 42 USCA § 18001 (2010).

<sup>131</sup> *Id.*

<sup>132</sup> Patrick Cox, *United Kingdom, Rationing by cost*, [www.rationinghealth.org](http://www.rationinghealth.org) (2012).

<sup>133</sup> *Id.*

<sup>134</sup> *Id.*

The difficulty of allocated limited healthcare resources is the same for the United States, Great Britain or any other country.

Governor Palin's "death panels" claim is misleading as to what rationing actually is and what the IPAB will actually do. She does bring attention to the fact that cost minded decisions do need to be made. President Obama also brings attention to the difficult decisions that must be made. Both claim they believe medical experts and doctors should make these decisions alongside their patients. These politically convenient views only sidestep the reality and necessity of rationing. The question is who does the rationing, how do they ration, and to what extent. The ethical dilemma is how to balance that.

## VI. Conclusion

The first line of Sarah Palin's infamous 2009 Facebook post is posed as a question by asking, "And who will suffer most when they ration care?"<sup>135</sup> This is clearly not the right question and misses the reality and necessity of rationing healthcare. Rationing in healthcare will continue, so under the ACA the IPAB will have to make recommendations on how to allocate limited Medicare dollars. Even though they may not ration explicitly, they will inevitably include implicit rationing. Our hybrid public private healthcare system will be around for a while and even though the ACA makes many changes the combination of private and public health insurance in this country will only increase and become even more intertwined.<sup>136</sup> Every nation must make clear eyed decisions on how to allocate those resources as they see fit. By understanding the premise of Governor Palin's argument and understanding the IPAB and

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<sup>135</sup> Sarah Palin, *Statement on the Current Health Care Debate*, [www.facebook.com](http://www.facebook.com) (Aug. 7, 2009).

<sup>136</sup> 42 USCA § 18001 (2010).

rationing itself, the American people can have a true understanding of the serious decisions regarding the future of healthcare.